June 25, 2002

To: All Medicare+Choice Organizations
Section 1876 Cost Contractors

From: Gary A. Bailey,
Director, Health Plan Benefits Group

Re: Implementation of Medicare + Choice provisions contained in the Public Health Security and Bioterrorism Response Act of 2002

The Public Health Security and Bioterrorism Response Act of 2002 ("The Act") (Public Law 107-188) includes changes to certain provisions of the Social Security Act governing the Medicare+Choice program. The Act:

- Changes the deadline for Medicare + Choice organizations to submit the Adjusted Community Rate Proposals (ACRPs) from July 1 to the second Monday in September (i.e., September 9 in 2002) for 2002, 2003, and 2004.
- Delays implementation of the lock-in rules for three years (until 2005). Therefore, through December 31, 2004, beneficiaries can make unlimited elections out of M+C plans and can make elections into Original Medicare or any M+C plans that are open for enrollment under the same terms that applied in 2001.
- Delays the open enrollment period for newly eligible individuals and institutionalized individuals until 2005.
- Changes the span of the annual election period (AEP) from the month of November to November 15 through December 31.
- Changes the date of the annual announcement of Payment Rates from March 1st to the second Monday in May for 2004 and 2005.

The purpose of this memorandum is to provide you with information on how to implement these provisions.

The Contract Year 2003 renewal/non-renewal instructions issued on May 3 and all other CY2003 ACR, PBP, and submittal instructions still apply except as noted in the attached timeline and instructions. A list of questions and answers is also attached.

There is currently an open forum conference call scheduled for **Thursday, July 11, 2:00-4:00 Eastern Time**. We will be using this time to discuss these instructions. To participate in the call, dial in at **1-800-837-1935**; the conference ID is 2814064. The conference call will have an encore feature in which you may call in and listen to the conference call up to 48 hours after its conclusion. For the encore feature, call 1-800-642-1687.

Questions regarding ACRPs may be directed to CMS at ACR2003@cms.hhs.gov. Questions regarding the lock-in delay may be directed to CMS at lockinquestions@cms.hhs.gov.

Revisions to the Contract Year 2003 Renewal/Non-Renewal Instructions Due to Legislative Changes

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CONTRACT YEAR (CY) 2003 CALENDAR UPDATES

The following are revisions to the calendar provided in the 2003 Renewal/Non-renewal Instructions released on May 3, 2002:

M+C RENEWAL PROCESS

2002	
June 3	• CMS begins accepting CY2003 ACRPs via HPMS and CY2003 marketing material.
July 26	• Final date for M+COs to submit **CY2002** marketing materials for CMS's review and approval. • M+COs should consider submitting their CY2003 Summary of Benefits (SB) and annual notice of change (ANOC) materials to CMS regional offices so that these materials can be reviewed and approved prior to the October 29th publication date of the Medicare Personal Plan Finder and Medicare Health Care Compare.
August 1	• M+COs must submit partial county requests to CMS for review and approval. • In order to make adjustments in HPMS, M+COs must advise CMS if they intend to not renew a county for individuals and remain in the county for employer group members.
August 31	• M+COs are required to include information in CY2002 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2003.
September 9	• Final day for M+COs to submit CY2003 ACRPs via HPMS. • Deadline for M+COs with employer-only plans to renew their CY2003 ACRPs via HPMS. • Section 1876 Cost-based contractors may voluntarily submit a PBP so information on benefits is included in *Medicare &You,* "Medicare Personal Plan Finder", and Medicare Health Plan Compare. • Final date for M+COs to send CY2003 ANOCs and SBs to CMS regional offices in order to ensure review, approval, and receipt by members before October 30 deadline. Note: If the M+CO follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB into CMS is October 19. • Final date for M+COs to send Modified Annual Notice of Change letter, which includes information on member's passive election, to their regional office for review and approval in order to meet M+C plan termination and service area reduction notification requirements and ensure that beneficiaries are notified by the October 2 deadline. • M+COs may begin marketing CY2003 benefits to Medicare beneficiaries through public media once the marketing materials

	receive approval from CMS. If the organization's ACR has not been approved, a disclaimer, "pending Federal approval", must be used on all approved marketing materials.
September 16-17	• M+COs preview the Medicare & You CY2003 items prior to CMS publication.
September 27	• Tentative date the Model CY2003 EOC will be made available to all M+COs.
October 7	• Final date to review and approve the CY2003 ACRPs submitted by M+COs offering one or more plans with a benefit reducing the Part B premium.
October 7-8	• M+COs preview plan data to be posted in "Medicare Personal Plan Finder" and "Medicare Health Plan Compare" prior to Internet release.
October 15	• M+COs that will not implement HIPAA Transactions and Code sets by October 16, 2002, must submit a HIPAA Compliance Extension form.
October 16	• M+COs not requesting an extension for HIPAA compliance must implement standards for HIPAA transactions and code sets.
October 15 – October 30	• CMS mails *Medicare & You* for CY2003, which will contain health plan benefit and cost information.
October 29	• CMS publishes plan data in "Medicare Personal Plan Finder" and "Medicare Health Plan Compare" on the Internet.
October 29	• Final date for marketing CY2002 plans (i.e., benefit packages) to Medicare beneficiaries through public media. Note: If the M+CO began marketing the CY2003 benefit packages any time between September 9 and October 29 (but no earlier than September 9), it must cease marketing CY2002 plans on the date it begins marketing the CY2003 benefit packages.
October 30	• For M+COs: CY2003 ANOC letters (with SBs) due to beneficiaries. M+COs must mail ANOC letters before this date to ensure receipt by enrollees by October 30. *Note: All marketing presentations and mailings to beneficiaries who inquire about CY2003 enrollment must include a CY2003 summary of benefits.*
November 1	• Tentative date for CMS's approval of all CY2003 renewal ACRPs. • M+COs may begin submitting Mid-Year Benefit Enhancements.
November 15 – December 31	• Annual election period (all M+COs)

2003	
January 1	• Effective date for CY2003 plan benefits.
February 1	• First effective date for Mid-Year Benefit Enhancements.
March 1	• Deadline for distributing CY2003 EOCs to plan members.
April 14	• M+COs must implement HIPAA Privacy standards.
October 16	• M+COs that requested an extension for HIPAA compliance must implement standards for HIPAA Transactions and Code sets.

M+C NON-RENEWAL PROCESS

2002	
July 1	• CMS final non-renewal instructions and beneficiary plan withdrawal Qs & As posted on the CMS website (www.cms.hhs.gov).
August 1	• The model final notification to beneficiaries, the state specific final notification letter, and a model public notice are posted on CMS website (www.cms.hhs.gov). • M+COs must submit partial county requests to CMS for review and approval. • In order to make adjustments in HPMS, M+COs must advise CMS if they intend to not renew a county for individuals and remain in the county for employer group members.
September 9	• Deadline for M+COs to submit a non-renewal or service area reduction notice to CMS.
September 10 – 12	• CMS issues an acknowledgement letter to all M+COs that are not renewing or are reducing their service area.
September 13	• CMS approves the final notification letter. • CMS will release a SEP letter to remaining M+COs.
September 16	• CMS will release information on non-renewals.
October 2	• M+COs must publish a CMS-approved notice in one or more newspapers of general circulation in each community or county in their contract area. • The final notification letter must be in the beneficiaries' hands.
November 18	• CMS issues "close out" information/instructions to M+COs that are not renewing or are reducing their service area.

Note: The Calendar for the 2003 Cost Plan Non-Renewal process has not changed.

DELAY IN ACR DUE DATE

ACRP Submissions

The final date for M+COs to submit their contract year (CY) 2003 ACRPs (ACR & PBP) is Monday, September 9. HPMS began accepting ACRP uploads on June 3. M+COs may upload their ACRP submissions one or more times from June 3 to September 9. CMS will accept resubmissions after September 9 *only* when requested by an ACRP desk reviewer.

The paper copy of the ACR, including the appropriate signatures and any supporting documentation, must be mailed to LMI and postmarked by September 9. CMS must receive all requests to consolidate health care component costs on Worksheet B by August 26.

The CY2003 renewal/non-renewal instructions issued on May 3 and all other CY2003 ACR, PBP, and submittal instructions still apply to the September 9 ACRP submissions except for the changes noted in this document. You can find the renewal/non-renewal instructions on the CMS website at http://cms.hhs.gov/healthplans/letters and the other resources at www.cms.hhs.gov/healthplans/acr. You can send questions to CMS at ACR2003@cms.hhs.gov.

CMS Contact: Theresa Conrad, 410-786-7635

Non-renewals

M+COs have until September 9, 2002 to notify CMS in writing of their decision whether to renew their M+C contract or whether to reduce their service area for CY2003. Partial county non-renewal requests are now due in writing to CMS by August 1 to allow CMS time to decide whether the conditions for an exception to the county integrity rule have been met. As indicated in the CY2003 renewal/non-renewal instructions issued on May 3, M+COs non-renewing contracts in all or part of a service area must send a CMS-approved notice to beneficiaries by October 2 advising them of alternatives for obtaining benefits under the M+C Program and explaining their Medigap rights.

M+COs that intend to request a waiver from CMS permitting them to non-renew M+C plans for individuals in a county, but continue to serve the employer group health plan members in the county, must notify CMS in writing by August 1 in order for the HPMS system to accommodate this request. This notice should be sent to Rosanna Johnson.

CMS Contact: Rosanna Johnson, 410-786-1148

Marketing Materials

Annual Notice of Change and Summary of Benefits

All enrollees must receive the CY2003 ANOC and SB by October 30. To meet this date, the ANOC and the SB should be submitted to the regional office no later than September 9. M+COs are encouraged to submit their ANOCs and SBs earlier than this date if they wish to market their

2003 benefits prior to the release of the Medicare Personal Plan Finder and Medicare Health Plan Compare on October 29.

To aid M+COs in meeting the October 30 deadline, marketing review will be streamlined as follows:

- As with the standardized SB, all M+COs that follow the model ANOC will be given a 10-day marketing review period. In order to meet the October 30 time frame, we strongly encourage M+COs to take advantage of this 10-day review opportunity.

    - Note: When submitting marketing material that an M+CO believes should be reviewed under the 10-day review period, the M+CO must indicate this by checking the appropriate box on the marketing material transmittal sheet.

- CMS will allow M+COs to release the 2003 ANOC and SB prior to approval of the ACRP (i.e, which includes the ACRP supporting documentation and the signed certification in Worksheet A). All ANOCs and SBs must include a disclaimer that the benefits and cost-sharing amounts contained in the documents are *"pending Federal approval."* This disclaimer need not appear at every point in which benefits, cost sharing, and premiums are discussed, and may instead appear once on the ANOC and once on the SB. The disclaimer must be of the same font and size as the rest of the document.

- M+COs have the option to submit the SB and ANOC without the ACR-related data included in the template, i.e., to submit the SB without the Benefit Matrix (Part II) and the ANOC without the benefit/cost-sharing changes. **M+COs that take advantage of this option are encouraged to submit their ANOC and SB (Section III) templates prior to the September 9 deadline, so they may take advantage of receiving approval of marketing materials even earlier.** The CMS Regional Offices will then review and approve the templates. Once the templates are approved, the M+CO may insert its ACR-related data and then print and mail the documents.

    - Note 1: If the M+CO's approved ACR differs from the mailed marketing materials, the M+CO is required to mail all enrollees an addendum before January 1, 2003. Additionally, SBs will need to immediately reflect the changes included in the addendum for use in pre-enrollment marketing.

    - Note 2: Between the time the Regional Office approves the template and the time the M+CO begins to insert ACR-related data, it is possible that the M+CO will have received approval of its ACR (as shown on HPMS). In these cases, the M+CO should insert the CMS-approved ACR-related information and can remove the disclaimer.

- CMS will suspend the final verification requirement again for the 2003 ANOC and SB. The M+CO will not be required to send the Regional Office a "camera ready copy" of the ANOC and SB before it can print and mail the documents. Instead, the M+CO must send a copy of what is mailed to all members to the Regional Office for its files at the same time it is mailed to members.

The model 2003 ANOC has been revised to reflect these changes. It is included as an attachment to these instructions.

Evidence of Coverage

CMS expects to make the model 2003 EOC available to M+COs by September 27. All EOCs must be mailed to members by March 1, 2003.

Other Marketing Materials

In addition to the ANOC and SB, there are marketing materials an M+CO prepares as part of the enrollment package to encourage prospective enrollees to join its M+C plans. As with the ANOC and the SB, M+COs will be allowed a streamlined approach to approval of these materials.

Specifically, as with the ANOC and SB, M+COs may release materials prior to approval of the official ACRP when using the "*pending Federal approval"* disclaimer and may submit materials to the Regional Office in template format (i.e., without the ACR-related information included in the material). In the event the M+CO's marketing materials differ from the information contained in the CMS-approved ACR, the M+CO must correct those materials as soon as possible.

CMS will also suspend final verification requirements for these materials as long as the M+CO sends a copy of what is made available to members/prospective enrollees to the Regional Office for its files at the same time it is available to members/prospective enrollees.

Since there is no CMS model for these types of materials, the 45-day marketing review period will apply. However, **M+COs can still take advantage of the chance to submit template-only material prior to September 9 so they may complete the marketing review process in time to market their 2003 products.**

CMS Contact: Mel Sanders, 410-786-8355

***Medicare & You* Handbook**

M+COs will have the opportunity to preview the plan data for accuracy September 16 and 17. If the M+CO finds inaccuracies in the data with respect to any of its plans, it should report these inaccuracies through the HPMS during this preview phase. However, due to the tight timeframes, there will be no review and approval of the premiums and benefits by CMS prior to the printing and mailing of the *Medicare & You* handbook. Therefore, the plan-specific information provided in the handbook will include a disclaimer as to the accuracy of the data. The disclaimer will say, "As submitted".

CMS Contact: Erin Pressley, 410-786-5569

Medicare Personal Plan Finder and Medicare Health Plan Compare

"Medicare Personal Plan Finder" and "Medicare Health Plan Compare" will be available on the Internet by October 29. The data will include a disclaimer that the information is *"pending Federal approval".* As ACRs are approved for M+COs, CMS will remove these disclaimers with the next update. CMS intends to update "Medicare Personal Plan Finder" and "Medicare Health Plan Compare" bi-weekly (i.e., every two weeks) during the time of the ACR approval process. In November, we will return to the regular monthly update schedule. M+COs will have the opportunity to preview the plan data for accuracy October 7 and 8. If the M+CO finds inaccuracies in the data with respect to any of its plans, it should report these inaccuracies through the HPMS during this preview phase.

CMS Contact: Valerie Hartz, 410-786-6013

LOCK-IN DELAY & ANNUAL ELECTION PERIOD CHANGE

General Information

The Act effects two key M+C enrollment provisions:

1. **Lock-In** will be delayed for three years; therefore, through December 31, 2004 beneficiaries can make unlimited elections out of M+C plans and can make elections into any M+C plans that are open for enrollment under the same terms that applied in 2001. In conjunction with this change, the Open Enrollment Period for Newly Eligible Individuals (OEPNEW) and the Open Enrollment Period for Institutionalized Individuals (OEPI) have also been delayed until 2005. The impact of the delay of the OEPNEW and OEPI until 2005 is that newly eligible and institutionalized individuals will have the same election rights (i.e., OEP) as all other beneficiaries through 2004.

2. **The AEP** will be changed from the month of November to November 15 through December 31 for 2002, 2003, and 2004.

Beginning on June 12, 2002, the Open Enrollment Period (OEP) is continuous through December 31, 2004. M+C plans may voluntarily close for enrollments during the OEP, as before. However, as under previous rules, all M+C plans must be open during the AEP (which will be November 15 through December 31 for 2002) unless they have an approved capacity waiver. M+COs wishing to do this should follow procedures previously used for this purpose. (More information on these procedures is provided below under "Systems Implications".) A plan that voluntarily closes may re-open at a later date, as before. Plans must always accept disenrollment requests as Original Medicare is always open during an OEP.

As a result of this legislative change, we are taking the following steps:

- Chapter 2 of the Medicare Managed Care Manual, including current model enrollment notices, will be revised as part of the next quarterly update (scheduled to be released in July).

- Model marketing materials (i.e., Evidence of Coverage, Summary of Benefits, Annual Notice of Change) will be revised.

- Updated information, as needed, will be posted on the Medicare managed care website-currently named "Election Period Changes for 2002" (http://cms.hhs.gov/healthplans/lockin/) OR "Enrollment" (http://cms.hhs.gov/enrollment/)

- Language referencing the AEP and lock-in in *Medicare & You* 2003 will be updated prior to being mailed out to beneficiaries.

- We will be providing information to our partners such as SHIPs, NMEP, and the Social Security Administration.

In order to notify beneficiaries in a timely manner that this change has taken place, M+C organizations are permitted to remove language referencing lock-in from their marketing materials without prior approval from CMS Regional Offices (ROs). In addition, CMS is providing brief model language that M+C organizations may include in their ANOCs notifying members of the delay. M+C organizations may also use this model language in other beneficiary information materials -- as long as the model language is used verbatim -- without CMS review.

We understand that prior to June 12, 2002, M+COs may have communicated with their members and potential enrollees, informed them of the lock-in rules, and/or taken an action (i.e., denial of disenrollment or enrollment) that was appropriate at that time. We do not expect M+COs to contact these individuals and inform them that there has been a change in the law unless they wish to do so.

Questions may be directed to CMS at lockinquestions@cms.hhs.gov.

Systems Implications

CMS' Managed Care system will not apply the election limits; however, M+COs who have made systems changes to comply with the lock-in provisions can submit data in the revised transaction formats. They will not be rejected. A systems letter, dated June 13, 2002, provides detailed data submittal instructions based on The Act. In general, the PBP Identifier and the Application Signature Date are still required. The Institutional Flag and the Type of Election are no longer required. Plan Benefit Package (PBP) correction transactions may be submitted as early as the July payment cycle, but they will not be processed until the August payment cycle. Effective with the August 1 reports, the new Transaction Reply codes and the PBP Identifiers as submitted by the M+COs will be displayed.

CMS Contact: Kim Miegel, 410-786-3311

M+COs use the HPMS Voluntary Plan Closure module to report voluntary plan enrollment closures to CMS. Because of lock-in, CMS had disabled the months of July through December 2002 for voluntary plan closure data entry. In light of the recent legislative changes to lock-in, we are reinstating the remaining months of 2002 (i.e., August through November 14) to allow M+COs to report enrollment closures. M+COs can begin reporting these closures on July 1, 2002 in HPMS. Voluntary plan closure notes will be available on Medicare Personal Plan Finder and Medicare Health Plan compare starting August 15. This information will be located under the "Important Notes" section of the detailed cost and benefits charts."

CMS Contact: Lori Robinson, 410-786-1826

ATTACHMENT MODEL ANNUAL NOTICE OF CHANGE - January 1, 2003

Date: [No later than] October 2, 2002 (Modified ANOC)
October 30, 2002 (ANOC)

Member Name, Medicare Number
Address
Member Number
Health Plan Name

Dear (member name):

Starting January 1, 2003, the monthly premium that you pay to {Health Plan Name} will (increase/decrease) from $____ to $____ **OR** (stay the same at $____).

[*"Modified" ANOCs due to enrollees by October 2: M+COs that wish to provide for enrollees of a terminated M+C plan to "elect" a different M+C plan by taking no action must insert the following information.* The notice must inform enrollees that if they wish to enroll in the M+C plan in question, they need take no action, and they will be enrolled in that plan effective January 1. The notice must also provide instructions on how these enrollees can choose not to elect the other M+C plan (i.e., by indicating that they do not wish to make this election, which would return them to Original Medicare, or by electing a different plan), and must provide information on the enrollee's Medigap rights, which apply if they do not elect the other M+C plan offered by the M+CO.]

[*If the organization lists more than one plan offering on the enclosed SB, the organization must identify the specific plan in which the member is currently enrolled. In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information. If the M+CO lists more than one plan offering on the SB enclosed with the ANOC, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB, and to note in the ANOC that other plans are available in the service area and that these plans are listed on the enclosed SB.]

{*Health Plan: Insert whichever of the two following sentences is appropriate for your circumstance:* (1) "Medicare has reviewed and approved the changes in benefits, premiums, and other cost sharing and plan rules included in this letter and on the enclosed Summary of Benefits" or, (2) "The changes in benefits, premiums, other cost sharing and plan rules included in this letter and on the enclosed Summary of Benefits are pending Federal approval."} All changes begin January 1, 2003, and will be in effect through December 31, 2003.

[Clearly describe all benefit changes, including changes in cost sharing, annual drug cap, drug coverage (i.e. generic), and any new benefits that will be offered by the plan in 2003

or that will be covered by Medicare. Also describe any benefits offered in 2002 that will no longer be offered by the plan in 2003.

[Clearly describe any optional supplemental benefits and the premiums for those benefits. A description of the process that the member must follow to elect optional supplemental benefits must also be included.]

[*The following language regarding enrollment "lock-in" is optional* -- You may have heard about new rules that went into effect in 2002 that limited how often and when you were allowed to switch Medicare health plans. On June 12, 2002, a new law passed that delayed these rules until 2005. Now, you can switch plans at any time for any reason as long as the plan is accepting new members.]

A new Evidence of Coverage (will be sent to you by March 1) **OR** (will be sent to you at a later date). A Summary of Benefits is also enclosed. We are required to use the Summary of Benefits for both current members, like you, as well as for people who are thinking about enrolling in {Health Plan Name}. This means that some of the language at the beginning of the document may make it seem like you are not already a member of {Health Plan Name}. Rest assured that you are a member of {Health Plan Name} and will be one for the coming year if you do nothing to change your Medicare coverage.

The following information is available upon request:

- Additional information from CMS by calling 1-800 MEDICARE.
- Additional information from {Health Plan Name} on the procedures we use to control utilization of services and expenditures.
- Additional information on the number and disposition in aggregate of grievances and appeals filed by members of {Health Plan Name}.
- A summary description of the method of compensation for physicians used by {Health Plan Name}.
- A description of our financial condition, including a summary of our most recently audited statement.

If you have any questions about these changes or if you would like additional information, please call our Member Services Department, Monday through Friday, (hours of operation) at (phone number). [Include a TTY/TDD phone number "for the hearing impaired."]

We look forward to serving you now and in the future.

Sincerely,
Plan Representative

ENCLOSURE - 1/2003 Summary of Benefits